STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

Bureau of Automotive Repair Licensing
P.O. Box 989001, West Sacramento, CA 95798-9001
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www.autorepair.ca.gov

REQUEST FOR SPECIAL ACCOMMODATION DURING ADMINISTRATION OF WRITTEN BAR LICENSING EXAMINATION

In compliance with the Americans with Disabilities Act (ADA), the Bureau of Automotive Repair (BAR) provides "reasonable accommodation" for applicants with disabilities that may affect their ability to take required examinations. Accommodations provided for difficulties reading/understanding English are provided only when a disability is diagnosed by a licensed medical professional, as described on page 2.

It is the applicant's responsibility to notify BAR of the accommodation(s) desired. We are not required to provide alternative arrangements if we are not aware of your needs. All requests will be considered on a case by case basis. You will receive written confirmation once all requirements have been met. The information requested on this form and any documentation regarding your disability will be considered strictly confidential.

Before an exam can be scheduled with the accommodations that you have requested, your request and supporting professional verification must be submitted to the Licensing Unit. BAR will not pay any costs you may incur in obtaining the required documentation. However, BAR will pay for any reasonable accommodations that are made for you at the examination site.

You must complete the following:

My disability is: _____

_____

My disability impairs my ability to accurately exhibit knowledge and skill on the examination in the following manner: _____

_____

The reasonable accommodation(s) I am requesting are:

_____ *Wheelchair access*

(If your request is limited to wheelchair access, professional verification & medical release are not required. Complete ONLY PAGE 1 OF THE FORM, sign and date it and return it to the above address. In all other cases, every page, including this page, must be completed and the form signed in the appropriate places.)

Printed Name: _____ Signature: _____ Date: _____

Professional verification of your disability is required for the accommodations listed below.

Complete ALL SECTIONS OF THIS REQUEST, sign and date it and return it to the above address.

Professional verification of your disability must be submitted to BAR on the letterhead stationery of the licensed medical professional. The medical professional providing the verification must have appropriate education and experience in evaluating your type of disability and must state their qualification in the verification letter.

The reasonable accommodation(s) I am requesting is:

_____Large print exam

_____Written instruction as accommodation for hearing impairment

_____Scribe as accommodation for visual or motor impairment

_____Other - Describe: _____

NOTE: The health care provider may make a copy of the medical release (page 4) for his or her records.

The evaluation(s) must respond to all of the following items in order for the request to be considered:

1. The history, nature and extent of the disability.
2. The test(s) performed to diagnose the disability.
3. The effect of the disability on your ability to perform under normal testing conditions.
4. What specific special accommodation for the multiple-choice written examination the medical or psychological professional is recommending and how that accommodation is related to your disability.
5. Name, title and telephone number of the medical or psychological professional.
6. Original signature of the medical or psychological professional.
7. Professional license or certification number of the medical or psychological professional.
8. Description of professional training and experience in evaluating this type of disability.

I certify under penalty of perjury of the laws of the State of California that the foregoing statements and those in any required accompanying documents or statements are true. I understand that false information may be cause for denial or loss of license and that BAR may obtain an independent assessment of my disability described on this form by a second professional at BAR expense.

Printed Name: _____
Applicant Full Name

Signature: _____
Applicant Signature

Address: _____
Street City State Zip

Day Phone #: _(_____)_____
Area code Telephone number Date

HIPAA-COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the use and/or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

Patient Name: Date of Birth:

Persons/organizations authorized to provide the information:

California Department of Consumer Affairs, Bureau of Automotive Repair ("Bureau") Licensing Unit, P.O. Box 989001, West Sacramento, CA 95798-9001, is authorized to receive and use the information in connection with my request for licensing testing accommodations. I further authorize that a photocopy of this medical release may be used by the **Bureau** to order and obtain medical information.

Specific description of information: complete medical record for all dates of service and all admissions including, but not limited to: history and physical exam; progress notes; office notes and letters; office chart; laboratory reports; diagnostic test reports including, but not limited to, x-ray, MRI, CT scan, bone scan, thermography reports; x-ray, MRI, CT scan, bone scan, thermography films; inpatient admissions and discharge reports; outpatient and emergency room admissions; complete hospital chart; healthcare records in your file from other providers; prescription records; operative reports; physical therapy.

The purpose of use or disclosure of patient information is for my request for licensing testing accommodations. Patient information may be used to determine my eligibility for special accommodation.. Patient information may not be redisclosed to any one for any purpose.

I understand that this authorization will expire automatically 6 months from the date I sign the release unless I specific a longer or shorter duration.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, revocation will not affect any actions the provider took before it received the revocation. Also, I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by a revocation.

I understand that I may refuse to sign this form but that my eligibility for special testing accommodation will be affected if I do not sign this form.

I understand that I am entitled to receive a copy of this authorization.

Signature of patient or patient's representative **Date**

Address:

If a patient's representative signs this authorization, please complete the following:

Printed name of patient's representative

Relationship to the patient

Describe the representative's authority to act for the patient: